

MEMORIAL HOSPITAL AT GULFPORT
CERTIFICATION BY CUSTODIAN OF MEDICAL RECORDS

STATE OF MISSISSIPPI

COUNTY OF HARRISON

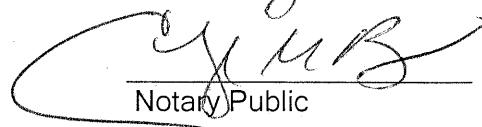
The undersigned being duly sworn does state on oath as follows:

1. That she is the duly authorized custodian of the hospital medical records of MEMORIAL HOSPITAL AT GULFPORT and has the authority to certify records.
2. That the within and annexed are true and correct copies of requested portions from the medical records of CARRUBBA, MARGUERITE, DOB: 09/15/1961 as described in the correspondence received for these records.
3. The within and annexed records were prepared either by the personnel of the hospital or its staff, physicians or by persons acting under the control either of them, in the ordinary course of hospital business at or near the time of the act, condition or event reported therein.

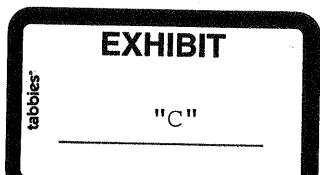


Signature of Custodian

SWORN AND SUBSCRIBED before me, this 20 day of May 2009


EJMB
Notary Public

MISSISSIPPI STATEWIDE NOTARY PUBLIC
MY COMMISSION EXPIRES SEPT 8, 2010
BONDED THRU STEGALL NOTARY SERVICE





PATIENT REGISTRATION

E15 TLA

MR 0000018673	PATIENT NAME CARRUBBA, MARGUERITE A								ROOM NO. 06168-00189	ACCOUNT NO.	
PATIENT ADDRESS 1023 E 2ND ST		CITY PASS CHRISTIAN								STATE ZIP CODE MS 39571	
SOCIAL SECURITY NO. 4 [REDACTED] 2	ADMISSION DATE 06/17/06	ADM. HOUR 2247	ADM. TYPE 1	ADM. SOURCE 7	ACCOG CODE ERC	DISCHARGE DATE ER	MED SV. CD 999	ADM. PHY 999	ATT. PHY. PHYSICIAN, E R	ATT. PHYS. NAME	
PATIENT PHONE (228) 669-4672	BIRTHDATE [REDACTED]	AGE 44Y	SEX F	ORIGIN 4	MARITAL S	RELIGION CHR	CHURCH PREFERENCE NO SPECIFIC/CHRISTIAN				
SPOUSE'S NAME CARRUBBA, RICHARD	NEAREST RELATIVE BROTHER					RELATIONSHIP			PATIENT'S MAIDEN NAME		
IN CASE OF EMERGENCY NOTIFY CARRUBBA, RICHARD			RELATIONSHIP BROTHER	ADDRESS 1023 E 2ND ST				CITY PASS CHRISTIAN	STATE ZIP CODE		
PRIMARY EMERGENCY PHONE (228) 452-4627	ALT. EMERGENCY PHONE	PATIENT EMPLOYER DISABLED									
ADDRESS OF EMPLOYER NONE		CITY GULFPORT								STATE ZIP CODE 39501	PHONE (228) 000-0000
OTHER EMPLOYER CARRUBBA, MARGUERITE A		CITY ADDRESS								STATE ZIP CODE	PHONE
GUARANTOR EMPLOYER DISABLED		CITY PHONE (228) 000-0000								GUARANTOR SOCIAL SECURITY NO. 428-29-1382	
ADDRESS OF GUARANTOR EMPLOYER NONE		CITY ACCIDENT								STATE ZIP CODE MS 39501	DATE TIME
ALLEGED ASSAULT											
NAME OF INSURANCE NO. 1 MEDICARE		NAME OF INSURANCE NO. 2 MEDICARE 1500 FORM								NAME OF INSURANCE NO. 3 MEDICAID SECONDARY	
GROUP NAME		GROUP NAME								GROUP NAME	
GROUP NO./POLICYHOLDER CARRUBBA, MARGUERITE A		GROUP NO./POLICYHOLDER CARRUBBA, MARGUERITE A								GROUP NO./POLICYHOLDER CARRUBBA, MARGUERITE A 601603411	
STREET ADDRESS PO BOX 23035		STREET ADDRESS PO BOX 23035								STREET ADDRESS MEDICAID PO BOX 23077	
CITY JACKSON		CITY JACKSON								STATE ZIP CODE MS 39225	STATE ZIP CODE MS 39225
Admitting Diagnosis (Record here or on Physical Examination)											
Days											
PRINCIPAL Diagnosis											
Codes											
Complications and/or Additional Diagnosis (List All)											
Principal Procedure											
All Other Procedures											
PRINTED BY: slh9337											
DATE 5/18/2009											
Consultation with _____											
DISCHARGE STATUS <input type="checkbox"/> ALIVE <input type="checkbox"/> AMA <input type="checkbox"/> DIED <input type="checkbox"/> TRANSFER <input type="checkbox"/> AUTOPSY <input type="checkbox"/> YES <input type="checkbox"/> NO											

CP4

1340B

CONSENT FOR ADMISSION TO HOSPITAL AND MEDICAL TREATMENT

I, M. M. Myself, give permission for such examination and treatment as the doctor(s) considers necessary or advisable for the care of CARRUBBA, Marguerite A (Patient's Name).

I understand:

1. That examination and treatment may include x-rays, drawing blood, medical/surgical care, medicines, anesthesia, or other healing measures.
2. That unexpected situations may arise and I now give permission, in the event I am later unavailable or unable to consent, for the doctor(s) to do what is necessary to save the health, or life, of the above named patient.
3. If I/the above named patient deliver a baby during this hospital stay, I give permission for such examination and treatment of that baby as the doctor(s) considers necessary and advisable.
4. The practice of medicine and surgery is not an exact science. There are no guarantees of success.
5. I have read and do understand this consent. I have had a chance to ask questions. The MHG staff answered my questions.

CONSENT TO RECORDING OR FILMING

I consent and authorize Memorial Hospital at Gulfport (including, but not limited to, its agents, servants, employees, staff members and volunteers) to make, maintain and use photographic, video, electronic/computer or audio media to document my condition or treatment for the purpose of identification, diagnosis and care and to exhibit, publish, televise or otherwise show said media for educational, performance improvement and related purposes and to permit others to do the same. I understand that there is a possibility that I may be identifiable in these media though my name will not be published unless I specifically authorized same in writing. I understand that I have the right to request cessation of the recording and filming and to revoke this consent by providing a written request/notice to the hospital Health Information Management Department at least twenty-four (24) hours before the media is used.

OTHER TERMS OF ADMISSION**I understand:**

1. Memorial Hospital at Gulfport will send me/the above named patient a bill.
2. Each physician specialist who examines or treats me or the above named patient will send a separate bill.
3. I am responsible for calling my insurance company before admission. The insurance company may reduce my benefits if I do not follow procedures. The hospital will contact the insurance company only as a courtesy.
4. If I am in a Managed Care Plan requiring approval of a primary care physician (PCP), the hospital will contact the PCP for instructions. My insurer may not pay if I receive services without their approval. In this case, I may be personally responsible for all charges for these services.
5. Memorial Hospital will not deny or delay treatment for any emergency medical condition in order to contact or receive approval from my insurance company or any PCP.

WAIVER OF CLAIM FOR LOSS OR DAMAGE TO PERSONAL PROPERTY**I understand:**

1. I may place my personal property in the Hospital safe.
2. I am responsible for loss of or damage to personal property that I do not place in the Hospital safe.

Witness AdamsTime 2242
Marguerite Carrubba
 Signature of patient or person permitted to sign for patient
JUN 17 2006Date JUN 17 2006
**Consent for Admission
to Hospital and
Medical Treatment**

 PRINTED BY: ER
 DATE: 5/18/2006

 CARRUBBA, MARGUERITE A
 PHYSICIAN, E R
 MR 0000018673
 DOB 1944-01-01
 ERC F 44Y
 0616800189


CONSENT FOR ADMISSION TO HOSPITAL AND MEDICAL TREATMENT
AUTHORIZATION TO RELEASE INFORMATION TO INSURER & ASSIGNMENT

I give permission to the Hospital to release medical information needed to process any claim related to this hospital stay against any of my insurance companies including automobile or other liability insurance companies. MHG can release this medical information only to the insurance company or any third party payor involved in this claim. Third party payors may be Medicare, Medicaid, CHAMPUS, CHAMPVA, automobile or other liability insurance, or any worker compensation plan. This permission is good for the time provided in MHG's Health Information Management Department policy unless I deliver to the Hospital written notice of cancellation.

I assign all insurance benefits and all third party claims up to the amount owed to Memorial Hospital at Gulfport and to any physicians who provide services to me or the above named patient. I direct third party payors to pay all benefits directly to MHG and these physicians.

I have given current and correct information about my insurance or other benefit status to the Hospital.

Witness J Adams

Date JUN 17 2006

X Marguerite Gough

Date JUN 17 2006

Signature of patient or person permitted to sign for patient

Marguerite Gough

JUN 17 2006

FINANCIAL AGREEMENT AND GUARANTY OF PAYMENT

In consideration of services rendered the above named patient, I unconditionally guarantee payment for services not covered by insurance or a benefit program while a patient in Memorial Hospital at Gulfport. I guarantee this payment within 60 days of final billing. If I do not pay in full, within that time, MHG may refer the bill to an attorney or collection agency. If the bill is referred to an attorney, either by MHG or by a collection agency, I will be responsible for attorneys' fees of up to 33 1/3% in addition to the amount of the bill and legal interest from date 60 days after final billing. I understand that the Hospital has the right to examine credit bureau files for financial information on unpaid debts. MHG may inform any credit bureau if any hospital bill not paid within 60 days of final billing.

I have read and understand this financial agreement. I have had a chance to ask questions. The MHG staff answered my questions.

Witness J Adams

Date JUN 17 2006

X Marguerite Gough

JUN 17 2006

Date JUN 17 2006

Signature of Patient or Guarantor of Account

Self

Relationship to Patient

Date JUN 17 2006

JUN 17 2006

PATIENT IS UNABLE TO CONSENT TO THE FOREGOING OR IS A MINOR, COMPLETE THE FOLLOWING:

PATIENT IS A MINOR _____ YEARS OF AGE / PATIENT IS UNABLE TO CONSENT BECAUSE _____

Witness _____

Date JUN 17 2006

Signature of patient or person permitted to sign for patient

Date JUN 17 2006

Important Message from Medicare received: _____ Clerk Initials _____ Date JUN 17 2006

Signature of Patient

CARRUBBA,MARGUERITE A

PHYSICIAN,E R 06/17/2006

MR 0000018673 DOB _____

ERC F 44Y

0616800189

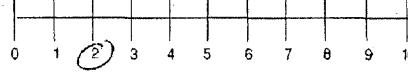
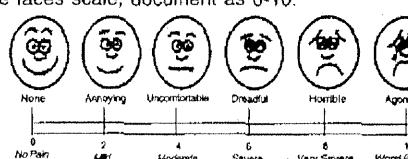
PRINTED BY: slh9337

DATE 5/18/2009



CP4

1720C

Name	Carrubba Marguerite			DOB	9-15-61	Age
Triage Level	3	<input type="checkbox"/> Emergent Priority	<input type="checkbox"/> Urgent Priority	<input checked="" type="checkbox"/> Non-Urgent Priority	Emotional Status:	<input type="checkbox"/> Comatose <input type="checkbox"/> Calm <input type="checkbox"/> Anxious <input type="checkbox"/> Combative <input type="checkbox"/> Cooperative <input type="checkbox"/> Hostile <input type="checkbox"/> Other: NONE
<input type="checkbox"/> 24-72 Hour Return <input type="checkbox"/> Same Complaint <input checked="" type="checkbox"/> New Complaint <input type="checkbox"/> Call Back		On the Job Accident: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date: 7/18/09		Mode of Arrival: <input checked="" type="checkbox"/> W/C <input type="checkbox"/> Ambulatory <input type="checkbox"/> Carried <input type="checkbox"/> Ambulance		Arrived With: <input type="checkbox"/> Friend <input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Parent
						Treatment Prior to Arrival: <input checked="" type="checkbox"/> None <input type="checkbox"/> Yes: <input type="checkbox"/> ice <input type="checkbox"/> IV <input type="checkbox"/> ACLS <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Anorexia <input type="checkbox"/> No Symptoms <input type="checkbox"/> In Foreign Country Recently
Visual Acuity	RT20/ LT20/ Both20/	TET Tox	LMP	Wt.	Ht.	TB Screen <input type="checkbox"/> Persistent Cough > 2 weeks <input type="checkbox"/> Wt Loss <input type="checkbox"/> Hx of TB <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Anorexia <input type="checkbox"/> No Symptoms <input type="checkbox"/> In Foreign Country Recently
Visual Acuity	RT20/ LT20/ Both20/	TET Tox	LMP	Wt.	Ht.	TB Screen <input type="checkbox"/> Persistent Cough > 2 weeks <input type="checkbox"/> Wt Loss <input type="checkbox"/> Hx of TB <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Anorexia <input type="checkbox"/> No Symptoms <input type="checkbox"/> In Foreign Country Recently
Date	Time	Chief Complaint: (In Patient's Words) 6/17-09 2240 96 assault @ Jail				
PAIN ASSESSMENT <input type="checkbox"/> None <input type="checkbox"/> Pt Uncooperative <input type="checkbox"/> Unable to assess due to acuity						
Pain now: (circle)						
 For PEDS, use faces scale; document as 0-10. 						
How long have you been in pain? 8-10						
Location(s) (specify each site) tip waist						
<input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input checked="" type="checkbox"/> Other						
What worsens pain? nothing						
What relieves pain? nothing						
Pain interferes with: <input type="checkbox"/> Function <input type="checkbox"/> Sleep <input type="checkbox"/> Appetite <input type="checkbox"/> Other						
What level of pain would be able to tolerate (Ex. Would allow you to sleep, perform ADLs, move post-op, etc.) 8-10						
ALLERGIES <input checked="" type="checkbox"/> NONE KNOWN						
Food, Medication, Latex, Tape, Iodine, Other <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Dyspnea <input type="checkbox"/> N/V <input type="checkbox"/> Other						
1. None						
2. None						
3. None						
Mental Status <input type="checkbox"/> Alert <input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Oriented X 3 <input type="checkbox"/> Combative <input type="checkbox"/> Lethargic <input type="checkbox"/> Drowsy <input type="checkbox"/> Unresponsive <input type="checkbox"/> Disoriented						
Speech <input type="checkbox"/> Coherent <input type="checkbox"/> Regular <input type="checkbox"/> Incoherent <input type="checkbox"/> Labored <input type="checkbox"/> Slurred <input type="checkbox"/> Shallow <input type="checkbox"/> Silent <input type="checkbox"/> Retractions <input type="checkbox"/> Absent						
Skin <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Jaundiced						
Pupils <input type="checkbox"/> N/A <input checked="" type="checkbox"/> Pupil <input type="checkbox"/> Unequal						
Skin Temp <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool						
PATIENT INFORMATION						
Emergency Department Nursing Record PRINTED BY: sh9337 DATE: 7/18/2009				CARRUBBA, MARGUERITE A PHYSICIAN, E.R. MR. 0000018673 06/17/2006 DOB: None ERC F 44Y 0616800189		

Memorial
Building a Healthier Community

Patient Name _____ Account # _____ Date: _____

Ongoing Assessment Treatment

2240 hrs 1st pt at 9 1/2 % alleged assault early AM bruises noted
Q arm slight swelling to b/p w/b, Pt stated she took her meds pt &
wellbeing, officer & meadow pt. Pt agitated & jumpy now. - Hillhouse
2315 Xanax .5g, 10 given for agitation. Tomy & bimboe. - Hillhouse 2320
to x-ray via stretcher. - Hillhouse 2345 Sheriff dept call re pt can
make a report of alleged assault. - Hillhouse 0010 local bullet
back from sheriff office stated pt had made report earlier today
and they wouldn't send anyone else out to take another. Pt to see
Steve Campbell a sheriff officer. - Hillhouse 0025 discharge construction
given. Tomy & patient requested I witness them take pictures. I informed
pt that witness would be unnecessary because origin of bruising
can't be determined since alleged incident happened several hours ago
plus she also had car accident. Bruise (C) arm purpled forearm + red
on (C) wrist area + slight rashness to b/p & chin area. Tylenol 325mg 10
given. Pt /t verbally understanding of discharge construction given.
- Hillhouse

Disposition Admitted To **Room No.** **Ready Room Time** Discharged Via Ambulatory
0030 AM/PM Printed By: slh9337 In Arms Wheelchair
 Ambulance

HISTORY AND PHYSICAL		Time: <u>2257</u>	 4000A		
CC/PHI:		FMH:			
		SH: +			
<p>Answered) This AM. Walking white in front answer answered by Susters. Throw on ground - Brown on white chick Answer They put her up from behind & am offed a bunch her face into floor - so neck soreness I am bad. Lice Belly.</p> <p>First BK, Never Prior BK Surgery & 5', BK surgery Heart @</p>					
<p>Ex. after saying VS & TPAK. Fresh Brown to ① ch. <u>the spine</u> Both arms. left elbow hand. left elbow forearm <u>TS spine</u> arm on bone or scaly or such or hard or cold arm for 5 min all gone. when</p>					
LAB:		X-RAY <u>old change</u>	Nurse Order		
		EKG	Trm/Int.		
		U.S.C.T.			
DIAGNOSIS: <u>multiple Bruise</u> <u>Tylen 325 mg po</u>					
<input checked="" type="checkbox"/> May Discharge <input type="checkbox"/> Admit Time _____	<input type="checkbox"/> Transfer <input type="checkbox"/> AMA	Condition on Discharge <input checked="" type="checkbox"/> Stable	I HAVE REVIEWED THE NURSES ASSESSMENT AND HISTORY <u>Mtg M</u>	<input type="checkbox"/> See Dictated Notes	
Patient Instructions <input type="checkbox"/> Sprain & Fracture, Severe Bruises <input type="checkbox"/> Medications <input type="checkbox"/> Head Inj (adult) <input type="checkbox"/> Fever <input type="checkbox"/> Back/Neck Inj <input type="checkbox"/> Vomiting/Diarrhea <input type="checkbox"/> Common Cold/Viruses <input checked="" type="checkbox"/> Sedation Instruction <input type="checkbox"/> Reducing High Fever <input type="checkbox"/> Orthopedic Appliance <input type="checkbox"/> Head Inj (Child) <input type="checkbox"/> Eye Inj <input type="checkbox"/> Wound Care/Animal Bite <input type="checkbox"/> Burns <input type="checkbox"/> Other					
DISCHARGE INSTRUCTIONS: <u>OTC Pain Med</u>					
Follow Up	<input type="checkbox"/> Make an appointment to see your regular physician		<input type="checkbox"/> Follow-up Visit in Emergency Department	<input type="checkbox"/> Have Sutures Removed in Days	
PATIENT/S/O VERBALIZED UNDERSTANDING OF INSTRUCTIONS <u>M. C. Hernandez</u>			I HAVE READ AND UNDERSTAND AND INSTRUCTIONS AND HAVE RECEIVED A COPY OF THEM <u>Marguerite Carrubba</u>		
Nurse Signature <u>M. C. Hernandez</u> Patient Signature <u>Marguerite Carrubba</u> PATIENT INFORMATION					



Emergency
 Department
 Physician
 Record
 PRINTED BY: slh9337
 DATE: 5/18/2009

CARRUBBA, MARGUERITE A
 PHYSICIAN, E.R. 06/17/2006
 MR 0000018673 DOB _____
 ERC F 44Y
 0616800189

RADIOLOGY REPORT
 CARRUBBA, MARGUERITE A DOB: [REDACTED] AGE: 44Y
 MR# G0000018673 CT# 927005 ACCOUNT # 0616800189
 SERV: ERC
 PT TYPE: ERC LOC: DIS - ERC EXAM DATE: 06/17/06
 ORD: LEVIN, PHILIP MD ADM: PHYSICIAN, E R MD
 ATT: LEVIN, PHILIP MD

Chk-in # Order Exam
 927005 0001 10648 XR SPINE CERVICAL AP&LAT
 Ord Diag: alleged assault

CERVICAL SPINE, FOUR VIEWS:

CLINICAL INFORMATION INCLUDES: Alleged assault. Neck and back pain.

The patient has had multi-level cervical fusion. There is degenerative narrowing of the C3-4 interspace with prominent endplate osteophytes. C4-C7 levels appear fused. There are internal fixation plates anteriorly at C3-4 and at C7-T1. Odontoid process appears to be intact. No abnormal prevertebral swelling. Similar imaging appearance noted on earlier MRI study on 05/01/06.

IMPRESSION:

ANTERIOR CERVICAL FUSION AT C4-T1. DEGENERATIVE CHANGES AT C3-4 ENDPLATES. NO ABNORMAL SUBLUXATION OR SPECIFIC ACUTE ABNORMALITY IS SEEN RADIOGRAPHICALLY.

Read By- F A LOVELL , M.D.

Released By- F A LOVELL , M.D.

Released Date Time- 06/18/06 0949

Typed By- JJS

PRELIMINARY UNLESS RELEASED

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
 LAWSON, STOREY, RADIOLOGISTS
 FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: slh9337
 DATE 5/18/2009

CARRUBBA, MARGUERITE A DOB: [REDACTED] AGE: 44Y
 MR# G0000018673 CI# 927006 ACCOUNT # 0616800189
 SERV: ERC
 PT TYPE: ERC LOC: DIS - ERC EXAM DATE: 06/17/06
 ORD: LEVIN, PHILIP MD ADM: PHYSICIAN, E R MD
 ATT: LEVIN, PHILIP MD

Chk-in # Order Exam
 927006 0002 10654 XR SPINE LUMBAR AP&LAT
 Ord Diag: alleged assault

LUMBAR SPINE, THREE VIEWS:

CLINICAL INFORMATION INCLUDES: Alleged assault. Neck and back pain.

The lumbar curvature is normal. There is moderate narrowing of the L5-S1 disc interspace. Vacuum disc at L5-S1. Mild narrowing at L4-5 interspace. There is no compression fracture or abnormal subluxation recognized. Symmetric SI joints.

IMPRESSION:

MODERATE L4-5 AND MILD L3-4 DISC INTERSPACE NARROWING. VACUUM DISC AT L5-S1. NO SPECIFIC ACUTE ABNORMALITY IS SEEN RADIOGRAPHICALLY.

Read By- F A LOVELL , M.D.

Released By- F A LOVELL , M.D.

Released Date Time- 06/18/06 0949

Typed By- JJS

PRELIMINARY UNLESS RELEASED

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
 LAWSON, STOREY, RADIOLOGISTS
 FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: slh9337
 DATE 5/18/2009



1800C

**INTERDISCIPLINARY PATIENT/FAMILY
EDUCATION FLOW SHEET**

INITIAL	PROVIDER SIGNATURE	INITIALS	PROVIDER SIGNATURE
26	Hulbertone		

DOCUMENTATION LEGEND:

Topic									
M - Medications E - Equipment	P - Procedure C - Consents	D - Diet DX - Diagnosis	A - ADL T - Treatment	FDI - Food/Drug Interaction Other					
Readiness to Learn									
Ability to Understand Verbal Instruction:	VP - Poor	VA - Average	VG - Good						
Cognitively Able to Understand:	CP - Poor	CA - Average	CG - Good						
Ability to Understand Written Instruction:	WP - Poor	WA - Average	WG - Good						
Barriers to Learning									
P - Physical R - Reading A - Auditory	V - Visual L - Language N - None	C - Cognitive CL - Cultural	M - Motivation AR - Age Related	R - Religious E - Emotional					
Who									
PT - Patient	F - Family		O - Other						
Learning Method Used									
D - Demonstration P - Pamphlet	TV - Video/TV/Audio V - Verbal Instruction	W - Written MED - Medication Instruction Sheet	GR - Group Work O - Other						
Comprehension									
1. Verbalized or demonstrated understanding. 2. Not receptive/cooperative. 3. Needs further instruction.		4. Medical condition limits understanding. 5. 6.							
DATE/ TIME	PROVIDER INITIAL	TOPIC	READINESS TO LEARN	BARRIERS TO LEARNING	WHO	LEARNING METHOD USED	COMPREHENSION	PREFERRED LEARNING METHOD: <i>Herb</i>	INFORMATION TAUGHT
4/19/06 2315	2	M VA	N	P/	V	V	1		<i>Classes for agitation</i>
1030	7	T VA	N	P/	V	V	1		<i>return if needed</i>
0830	9	T VA	N	P/	V	V	1		<i>OTC plain meds</i>



Interdisciplinary
Patient/Family
Education Flow sheet

PRINTED BY: 8149337
DATE: 04/19/2006

PATIENT INFORMATION

ERC ERC
CARRUBBA, MARGUERITE A
06/17/2006 MR 0000018673
PHYSICIAN, E R
DOB [REDACTED] 0616800189
F 44Y

